WASHINGTON OZAUKEE
PUBLIC HEALTH DEPARTMENT

Adult FLU Record

121 West Main Street, Port Washington, WI 53074 (262) 238-8170

Name: _____ Date of Birth: _____ Age: _____
(Last Name, First Name, Middle Initial)

Street Address: _____ Phone: _____

City/State/Zip: _____ ☐ Male ☐ Female

Race (Check one):
☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Other

Insurance Information (Check one):
☐ Medicare ☐ Medicaid ☐ BadgerCare ☐ No Insurance

Ethnicity (Check one):
☐ Hispanic
☐ Non-Hispanic

PLEASE ANSWER THESE QUESTIONS:	Yes	No
1. Are you the client or legal guardian?		
2. Is this person sick today with an illness more severe than a cold?		
3. Does this person have a serious life-threatening allergy to thimerosol (a mercury antiseptic/preservative), latex, eggs, gelatin, polymyxin B, neomycin or formalin?		
4. Has this person ever had a serious reaction to a flu vaccine?		
5. Has this person ever been paralyzed with Guillain-Barre Syndrome?		
6. Does this person get faint or light headed when receiving a "shot" or having blood testing?		

***Note**: Your immunization is placed in the Wisconsin Immunization registry, WIR. WIR helps your health care provider in record-keeping and tracking vaccines. Immunization information may be shared with health providers, PHD, schools, etc. according to WI State policy.*

I have been offered a copy and have read, or had explained to me, information about the privacy practices and the vaccine that I will be receiving. I understand the benefits and risks of the vaccine and ask that this vaccine be administered to me or the person for whom I am authorized to make this request. I also understand the cost of this vaccine is my responsibility and any balance not covered by Medicare/Advantage Plan will be billed to me directly.

Signature (circle: Client/Guardian): _____ Date: _____

Interview By: _____ Date: _____

2016 CDC VIS	Vaccine Manufacturer	Lot	Site
INFLUENZA – QIV/TIV	SF / GSK		RD LD

RN Signature: _____ Date Administered: _____
Vaccine Administrator

Office Use Only
Medicare Number: _____
Medicare Advantage Plan Insurance Provider: _____
Member/Subscriber ID Number : _____ Group #: _____

Clinic Site: _____ Billing: Flu-$30/HD-$50 Amount Paid_____ BILL: ☐